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Patient Perception, Preference and Participation

Patient perceptions of proactive medication discontinuation

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ABSTRACT

Objective: While many patients prefer fewer medications, decisions about medication discontinuation involve collaboration between patients and providers. We sought to identify patient perspectives on intentional medication discontinuation in order to optimize medication use.
Methods: We conducted 20 interviews and two focus groups with a convenience sample of patients (22 men, 5 women; mean age 66 years) at two US Veterans Affairs Medical Centers. We queried patients' experiences with and attitudes toward taking multiple medications, preferences about taking fewer medications, and communication with their providers about stopping a medicine. Transcripts were analyzed qualitatively.
Results: Three main themes emerged to create a conceptual model of medication discontinuation from the patient perspective: (1) conflicting views of medication, encompassing the sub-themes of desire for fewer medications, adherence, and specific versus general; (2) importance of patient–provider relationships, encompassing the sub-themes of trust, relying on expertise, shared decision making, and balancing multiple providers; and (3) limited experience with medication discontinuation.
Conclusion: Many patients who have a preference to take fewer medicines do not share their beliefs with providers and recall few instances of provider-initiated medication discontinuation.
Practice implications: Strengthening patient–provider relationships and eliciting patient attitudes about taking fewer medications may enable appropriate discontinuation of unnecessary medications.
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1. Introduction

Adverse outcomes from inappropriate medication use are pervasive, whether measured as adverse clinical events – estimated to occur in 25% of ambulatory care patients, increased health care costs or decreased quality of life [1]. These outcomes occur even within integrated health care such as at the United States Veterans Health Administration (VA), a national system providing comprehensive care to military Veterans. While medication adherence and medication reconciliation receive considerable attention, there has been less focus on improving intentional, proactive *discontinuation* of medications that may no longer be necessary or whose benefits no longer outweigh associated risks. Appropriately discontinuing medications prior to the occurrence of a side effect could lead to a reduction in adverse drug events and improved health outcomes, especially given the rarity of clinically significant adverse drug withdrawal events [2]. Although discontinuation is often thought of as a provider decision, patient perspectives of and communication about proactive discontinuation are critically important to understand.

Patient medication-taking behavior is influenced by many factors, including health literacy, socioeconomic status, perceived medication necessity, future health concerns and whether the drug provides symptom relief [3–5]. Further, patients' beliefs about their medications are dynamic and can fluctuate with changes in symptoms, competing health- and non-health-related demands and trust in the health care provider [4,6]. Others have described patients' general reluctance to take medications, with an associated interest in taking fewer medicines [7]. Patients also may prioritize some of their medications as less important to their

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health or change their opinion when provided with education [8–10]. These predisposing sentiments might then relate to the frequency with which patients "self-discontinue" medications, where they make the decision to stop a drug without discussing it with their health care provider [11]. Patients with severe chronic illnesses also have expressed interest in discontinuing treatment, even if temporary [12]. Despite the fact that many patients would like to stop medication, currently there is little guidance for providers and patients to effectively communicate and decide about discontinuation.

One feature of high-quality patient–provider communication is eliciting patient preferences, and failing to do so may lead to a "preference misdiagnosis" [13]. That is, providers frequently overestimate a patient's understanding of disease or their own awareness of the patient's preferences, potentially leading to the continued use of medications that may not be needed. Conversations about medications are often directed by providers, especially when discussing initial prescriptions as compared to renewals, since patients should only be expected to have knowledge about what they have experience taking [14]. However, little is known about when and how patients discuss discontinuation of medications with their providers. Further, it is unclear how primary care patients would respond to a suggestion from a clinical provider to intentionally discontinue a medication. Therefore, we sought to identify key patient elements that contribute to shared clinical decision making about intentional medication discontinuation.

2. Methods

We conducted a qualitative study using focus groups and in-depth interviews of patients seen at US Department of Veterans Affairs Medical Centers (VAMC). Focus groups capitalize on interaction between participants while interviews enable discussion of personal problems that patients may not wish to share with a group. Using both methods enhanced our study; however, we did not use the findings from one to inform the other.

2.1. Recruitment

To obtain our convenience sample, we identified 100 Veterans who were taking five or more medications and who had visited Primary Care at one of two VAMCs at least twice in the previous two years. We mailed them a letter and brochure to introduce the study, including a description of project objectives to understand the experience of taking multiple medications. Individuals who did not indicate that they wished not to participate were then contacted via telephone to assess their interest in participation. Additional potential participants (n = 27, 13 of whom participated) were identified by primary care providers. Those patients who wished to participate were scheduled for a focus group or interview, depending on their availability. Written informed consent was obtained from all participants; $50 compensation was provided. Institutional review boards at both sites approved the study.

2.2. Data collection

We conducted two 60–90 min focus groups (one with 3, one with 4 Veterans) and then 30–60 min semi-structured interviews with another 20 Veterans between November 2012 and April 2013. We developed a flexible interviewer's guide that queried patients' experiences with and attitudes toward taking multiple medications, preferences about taking fewer medications, communication with their providers about medications, and actual or hypothetical response to their provider suggesting to stop a medicine (see Table 1). The interviewer followed-up on unanticipated topics raised by participants. The focus groups used a similar guide to the interviews; AL and BB co-moderated the first focus group, and AL moderated the second. At the end of each interview, we explicitly reviewed the medication list obtained from the electronic health record to identify any medications that were no longer being taken, and if so, the reason(s) why.

Table 1
Interview guide.

1. We are going to talk about taking medicines and discussing medication-taking with your health care provider. We want to hear about your experiences with taking several medicines
   a. What is it like to take several medicines every day?
   b. Are there times when you do not take all of your medications? Can you tell me about that?
      i. Are there things that you can think of that would make it easier to understand how to take your medicines?
      ii. Can you tell me about the times when you forget to take your medicines?
   c. What do you do when your prescription runs out? (Referring to refills, calling in to request that)
   d. Some people have concerns about taking many medicines. What do you think?
   e. Sometimes people choose not to take their medicines. Can you think of a time when you chose not to take your medicine?
      i. What makes you decide not to take it?
      ii. Do you tell your doctor if you stop taking a medicine?
2. Now I want to talk about how you view your medicines
   a. Are there some medicines that people think are more important for you to take?
   b. Are there some medicines that you think are less important for you to take?
3. When you go to your doctor's visit, what kinds of discussions do you have about your medications? Do you talk about medications you are not taking or do not want to take?
4. Sometimes doctors think you should not be taking a specific medicine anymore. Have you ever had a provider tell you to stop taking a medicine? What did you think when he/she did that?
   a. Have you ever had one doctor suggest stopping a medicine that another doctor had prescribed?
   b. What would you think if your primary care provider suggested stopping a medicine that a specialist (such as the heart doctor or lung doctor) had prescribed?
   c. Have you ever had your VA provider change or stop a medicine prescribed by a community provider?
5. Do you have any final ideas that you would like to share before we finish?

2.3. Analysis

Focus groups and interviews were audio-recorded, transcribed verbatim and reviewed for accuracy. After data collection, all transcripts were analyzed qualitatively using procedures modified from grounded theory methodology [15], a systematic approach to deriving qualitative themes from textual data. This approach begins with open coding, where an investigator identifies key concepts emerging from the language used by participants and assigns one or more codes (descriptive phrases) to segments of text. Using NVivo qualitative analysis software [16], the lead investigator and two research assistants (TM, JC) inductively coded five interviews concurrently to develop a coding dictionary (i.e., a standardized ontology for this study); the remaining interviews were independently coded (AL – nine interviews, one focus group; TM – three interviews; JC – three interviews, one focus group), refining the dictionary as needed. The three coders met frequently to discuss coding progress and concerns, and the process was reviewed with a second investigator (BB). Next, detailed coded text segments were reviewed by two investigators (AL, BB) and condensed into broader themes. Prominent themes and exemplifying quotes were discussed by the research team, using constant comparison analysis.